Illinois Department of Public Aid

Medical Necessity Information
XOLAIR® (Omalizumab)

Patient Information

Patient Name:	Date of Birth:
Recipient ID Number:	Social Security#:

Prescriber Information

Prescriber Name:	License:	
Address:	City:	
Phone:	Fax:	DEA:
Specialty: ¡ Allergy ¡ ENT ¡ Pulmonology **Requests will be considered only when ordered by these specialists**		

Diagnosis

List Diagnosis: (Only approved for **asthma**)	**Severity of Asthma:** ¡ Mild intermittent ¡ Mild persistent ¡ Moderate persistent ¡ Severe persistent

Laboratory results

Positive skin or RAST test to a perennial aeroallergen ¡	Patient weight____ kg on date:
Pretreatment IgE level _____IU/ml on date: _____ (Submit copies of test results)	

Asthma Medication use History

Medication	Current Dose	Date Started	Is patient compliant?

Requested Dose (Circle)

150 mg/dose q 4wk	300 mg/dose q 4wk	
225 mg/dose q 2wk	300 mg/dose q 2wk	375 mg/dose q 2wk

Physician Signature: _____ Date: _____

Fax to 217-524-7264 Attn: Medical Committee. Approval, if granted will be for a 1-year period.

Created: **8/3/2004**